

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/19/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157318		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 12/11/2012	
NAME OF PROVIDER OR SUPPLIER PREFERRED HOME HEALTH CARE- VINCENNES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 5250 E US 36, SUITE 850 AVON, IN 46123			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
G 000	<p>INITIAL COMMENTS</p> <p>This visit was for a federal home health complaint investigation.</p> <p>Complaint #'s: IN00118584 and IN00120345- Unsubstantiated: Lack of sufficient evidence.</p> <p>Survey dates: 12/10-11/12</p> <p>Facility #: 005731</p> <p>Medicaid Vendor #: 200231350 A</p> <p>Surveyor: Marty Coons, RN, PHNS</p> <p>Preferred Home Health Care-Vincennes Inc is in compliance with the Conditions of Participation for home health agencies 42 CFR Part 481.10 Patient rights, 484.14 Organization, Services, & Administration, and 484.18 Acceptance of patients, plans of Care, and Medical Supervision as related to these complaints.</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN December 19, 2012</p>			G 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.